

STATE OF MICHIGAN
DEPARTMENT OF LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 89526-001-SF

v

Blue Cross Blue Shield of Michigan
Respondent

/

Issued and entered
This 9th day of September 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On May 1, 2008, XXXXX, on behalf of her minor son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* The Commissioner reviewed the request and accepted it on May 8, 2008.

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received Blue Cross Blue Shield's (BCBSM's) response on May 19, 2008.

The Petitioner is enrolled for health coverage through the State of Michigan PPO Plan, a self-funded group. BCBSM administers the plan. The issue in this external review can be decided

by an analysis of the Petitioner's health care benefits. Those benefits are defined in the State Health Plan *Your Benefit Guide* (the guide). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II FACTUAL BACKGROUND

The Petitioner sustained flame burns to his face, ears, neck, and bilateral upper extremities. As part of his treatment a compression burn mask was purchased on October 25, 2007, from a medical supplier that does not participate with BCBSM. The cost of this item of durable medical equipment was \$4,400.00. BCBSM approved \$867.00 for this device and, after applying a 10% copayment, paid the Petitioner \$780.30.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on January 29, 2008, and issued a final adverse determination dated March 5, 2008.

III ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's burn mask?

IV ANALYSIS

Petitioner's Argument

The Petitioner received burns on his face that required skin grafts. A silicone-lined burn face mask was made to apply pressure therapy and help heal the Petitioner's face. Using the mask could prevent contractures that would affect his speech and his oral intake, his ability to close his mouth, and possibly his ability to turn his head.

The Petitioner's doctor indicated that this burn face mask is medically necessary if the Petitioner is to make a full recovery. The Petitioner argues that since the mask is medically necessary and was received from a provider recommended by his doctor, that BCBSM should be required to pay the full amount charged.

BCBSM's Argument

BCBSM says that the guide clearly states that BCBSM pays its "approved amount" for covered services. The approved amount is defined as the lesser of the provider's charge or BCBSM's maximum payment level for the service. The guide does not guarantee that charges will be paid in full. Moreover, since the medical supplier in this case does not participate with BCBSM, it is not required to accept BCBSM's approved amount as payment in full and may bill the Petitioner for the difference between its charge and BCBSM's payment.

BCBSM says further that since the medical supplier is not part of the PPO network and the Petitioner did not receive a written referral from a PPO physician, the approved amount for the burn face mask was subject to a 10% copayment.

BCBSM argues that it has paid its approved amount minus a 10% copayment or \$780.30 to the Petitioner for his burn face mask. Therefore, BCBSM contends that it has paid the proper amount for the Petitioner's care and is not required to pay more.

Commissioner's Review

The medical supplier that provided the Petitioner's mask is a nonparticipating provider. The guide describes how benefits are paid when services are received from a nonparticipating provider. First, BCBSM pays an "approved amount" for covered services -- it does not guarantee that provider charges will be paid in full. "Approved amount" is defined in the guide on page 80 as "the BCBSM maximum level or the provider's charge for the covered service, whichever is lower." The only difference between the amount paid for services from participating and nonparticipating providers is a 10% copayment for nonparticipating providers since they are not part of the PPO network.

The amount charged by any provider may be significantly higher than BCBSM's payment level for the service. However, participating providers must accept BCBSM's approved amount as payment in full, regardless of the charge. Non-participating providers are free to demand payment

up to their entire charge. Since non-participating providers have not signed agreements with BCBSM to accept its approved amount as payment in full, the Petitioner, as the guide explains on page 17, “may also be responsible for any charge above BCBSM’s approved amount.”

The Petitioner did not use a participating provider, apparently because his doctor recommended the nonparticipating medical supplier that furnished the burn mask. Nevertheless, there is nothing in the language of the guide that requires BCBSM to pay more than its approved amount (minus a 10% copayment) for services or items from a nonparticipating provider, even if a participating provider was not available. The Petitioner remains responsible for the difference between BCBSM’s payment and the provider’s charge.

The Commissioner finds that BCBSM is not required to pay any additional amount for the burn face mask provided the Petitioner on October 25, 2007.

V ORDER

BCBSM’s final adverse determination of March 5, 2008, is upheld. BCBSM is not required to pay an additional amount for the Petitioner’s burn face mask.

This is a final decision of an administrative agency. A person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2).

A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.